		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007914

Facility Name: Covenant Home of Chicago

Address: 2725 West Foster Avenue (Number) Chicago (City) 60625 (Zip Code)

County: Cook

Telephone Number: (312)878-8200 **Fax #** (312)344-7516)

IDPA ID Number: 36-30959-32001

Date of Initial License for Current Owners: 7/1/1890

Type of Ownership:

XX	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
XX	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code	501(C)(3)		Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Barry C. Scutillo, CPA **Telephone Number:** 954 721-5222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/01 to 01/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard W. Olson
(Title) Vice President - Finance

Paid Preparer
(Signed) See attached Accountants Report (Date)
(Print Name and Title) Scutillo Blake McMillan & Joyce, PA
(Firm Name & Address) 8000 North University Drive, Ft. Lauderdale, FL 33321
(Telephone) (954) 721-5222 Fax # (954) 722-6692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	52	TOTALS	52	18,980	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,916	10,289	852	17,057	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,916	10,289	852	17,057	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.87%

D. How many bed-hold days during this year were paid by Public Aid? 69 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [XX] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 07/01/1890

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 6 and days of care provided 852

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 01/31/02 Fiscal Year: 01/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	142,946	10,820	12,169	165,935		165,935		165,935			1
2	Food Purchase		104,897		104,897		104,897		104,897			2
3	Housekeeping	49,546	6,482	48	56,076		56,076		56,076			3
4	Laundry	6,423	825	73,871	81,119		81,119		81,119			4
5	Heat and Other Utilities			25,710	25,710		25,710		25,710			5
6	Maintenance	10,116	7	778	10,901		10,901	224,115	235,016			6
7	Other (specify):*			2,345	2,345		2,345		2,345			7
8	**TOTAL General Services**	209,031	123,031	114,921	446,983		446,983	224,115	671,098			8
	B. Health Care and Programs											
9	Medical Director			5,335	5,335		5,335		5,335			9
10	Nursing and Medical Records	909,343	90,047	27,277	1,026,667		1,026,667		1,026,667			10
10a	Therapy		92	57,868	57,960		57,960		57,960			10a
11	Activities	50,864	1,699	16,000	68,563		68,563		68,563			11
12	Social Services	25,395	233	3,829	29,457		29,457		29,457			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	985,602	92,071	110,309	1,187,982		1,187,982		1,187,982			16
	C. General Administration											
17	Administrative	36,039		63,588	99,627	(4,507)	95,120	86,182	181,302			17
18	Directors Fees											18
19	Professional Services			28,034	28,034		28,034		28,034			19
20	Dues, Fees, Subscriptions & Promotions			10,237	10,237		10,237	(1,122)	9,115			20
21	Clerical & General Office Expenses	48,075	4,096	14,130	66,301		66,301	12,795	79,096			21
22	Employee Benefits & Payroll Taxes			265,844	265,844	4,507	270,351		270,351			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,807	2,807		2,807	(1,750)	1,057			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			498	498		498		498			26
27	Other (specify):*											27
28	**TOTAL General Administration**	84,114	4,096	385,138	473,348		473,348	96,105	569,453			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,278,747	219,198	610,368	2,108,313		2,108,313	320,220	2,428,533			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Home of Chicago #0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			14,006	14,006		14,006	88,812	102,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,642	1,642		1,642	(1,642)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			155,817	155,817		155,817	(155,817)				34
35	Rent-Equipment & Vehicles			255	255		255		255			35
36	Other (specify):*											36
37	**TOTAL Ownership**			171,720	171,720		171,720	(68,647)	103,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	(603)	14,269		13,666		13,666		13,666			39
40	Barber and Beauty Shops			5,248	5,248		5,248		5,248			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							28,470	28,470			42
43	Other (specify):*	9,639		26,186	35,825		35,825	(35,825)				43
44	**TOTAL Special Cost Centers**	9,036	14,269	31,434	54,739		54,739	(7,355)	47,384			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,287,783	233,467	813,522	2,334,772		2,334,772	244,218	2,578,990			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,786	30		9
10	Interest and Other Investment Income	(1,642)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,796)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,652)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	252,400		34
35	Other- Attach Schedule **Provider Part. Fee**	28,470	42	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 280,870		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 244,218		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Covenant Home of Chicago

ID# 0007914

Report Period Beginning: 02/01/01

Ending: 01/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing and Employee Recognition Exp	$ (35,825)	43	1
2	Non Allowable Travel, Auto, Seminar Exp	(1,750)	24	2
3	Promotion/Pub. Rel., Dues/Subs. Expense	(1,122)	20	3
4	Other Operating Revenue	(99)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38,796)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	224,115	0	0	0	0	0	0	0	0	0	224,115	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	224,115	0	0	0	0	0	0	0	0	0	224,115	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	86,182	0	0	0	0	0	0	0	0	0	86,182	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	20
21	Clerical & General Office Expenses	(99)	12,894	0	0	0	0	0	0	0	0	0	12,795	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,750)	0	0	0	0	0	0	0	0	0	0	(1,750)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,971)	99,076	0	0	0	0	0	0	0	0	0	96,105	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,971)	323,191	0	0	0	0	0	0	0	0	0	320,220	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Home of Chicago # 0007914 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,786	85,026	0	0	0	0	0	0	0	0	0	88,812	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,642)	0	0	0	0	0	0	0	0	0	0	(1,642)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(155,817)	0	0	0	0	0	0	0	0	(155,817)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,144	85,026	(155,817)	0	0	0	0	0	0	0	0	(68,647)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	28,470	0	0	0	0	0	0	0	0	0	0	28,470	42
43	Other (specify):*	(35,825)	0	0	0	0	0	0	0	0	0	0	(35,825)	43
44	**TOTAL Special Cost Centers**	(7,355)	0	0	0	0	0	0	0	0	0	0	(7,355)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,182)	408,217	(155,817)	0	0	0	0	0	0	0	0	244,218	45

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Ministries of Benevolence	100%	N/A		Swedish Cov. Hosp.	Chicago	Acute Pt. Care
Covenant Retirement Communities, Inc	100%	See Attached list	Various	Covenant Retire. Communities, Inc.	Chicago	Mgt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [XX] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Plant Ops, Maint. & Repair	$	Swedish Covenant Hospital	0.00%	$ 224,115	$ 224,115	1
2	V	30	Depreciation Expense		Swedish Covenant Hospital	0.00%	85,026	85,026	2
3	V	21	Admin & General		Swedish Covenant Hospital	0.00%	12,894	12,894	3
4	V								4
5	V	17	Management Services	63,588	Covenant Retirement Communities, Inc.	100.00%	149,770	86,182	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 63,588			$ 471,805	$ * 408,217	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [XX] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Consulting Services	$ 19,375	Covenant Retirement Communities, Inc.	100.00%	$	$ (19,375)	15
16	V		Detail:						16
17	V	19	Data Processing				7,164	7,164	17
18	V	19	Audit Services				5,439	5,439	18
19	V	19	Cost Report Preparation				3,000	3,000	19
20	V	19	Payroll Services				3,772	3,772	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	22	Pension Plan Expense	4,093	Covenant Retirement Communities, Inc.	100.00%	4,093		25
26	V								26
27	V	34	Rent Expense	155,817	Swedish Covenant Hospital	0.00%		(155,817)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 179,285			$ 23,468	$ * (155,817)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [XX] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities, Inc.
Street Address: 5115 North Francisco Ave., Suite 2000
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: ((773) 878-2294
Fax Number: ((773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Net Service Revenue	94,856,000	32	$ 5,391,331	$ 1,938,624	1,118,778	$ 63,588	1
2	19	Audit Services	Fixed Monthly Fee (1)	32	32	241,647	0	1	5,439	2
3	19	Data Processing	Fixed Monthly Fee(2)	32	32	474,064	Not Available	1	7,164	3
4	19	Cost Report Prep	Fixed Monthly Fee(3)	14	14	66,456	0	1	3,000	4
5	22	Pension Plan Expense	Fixed Monthly Fee(4)	32	32	125,977	0	1	4,093	5
6	19	Payroll Processing	Direct Cost	1	1	3,772	0	1	3,772	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17		NOTE:								17
18		(1) Audit services are allocated based upon an estimated fixed fee of $453 per month. The g/l account is adjusted at year end to actual.								18
19		(2) Data processing are allocated based on an estimated fixed fee of $597 per month.								19
20		(3) Cost report prep services are based on an estimated fixed fee of $250 per month.								20
21		(4) Pension plan expense is allocated based on an estimated fixed fee of $341 per month.								21
22										22
23										23
24										24
25	TOTALS					$ 6,303,247	$ 1,938,624		$ 87,056	25

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1				N/A			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interco. Note to/From CRC	XX		Working Capital	O/S Balance		(2,331,133)	(183,715)				6
7												7
8												8
9	TOTAL Facility Related						$ (2,331,133)	$ (183,715)			$	9
	B. Non-Facility Related*											
10	Gain/Loss Sale of Invest										1,642	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,642	14
15	TOTALS (line 9+line14)						$ (2,331,133)	$ (183,715)			$ 1,642	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Covenant Home of Chicago **#** 0007914 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007914

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,018 B. General Construction Type: Exterior Masonry Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [XX] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [XX] (a) Own the Equipment [XX] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [XX] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			N/A	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	N/A										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	N/A		$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 131,296	$ 11,278	$ 15,690	$ 4,412	8	$ 79,889	71
72	Current Year Purchases	36,140	2,728	2,102	(626)	8	2,102	72
73	Fully Depreciated Assets	38,277				8	38,277	73
74								74
75	TOTALS	$ 205,713	$ 14,006	$ 17,792	$ 3,786		$ 120,268	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 205,713	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,786	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 120,268	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Swedish Covenant Hospital

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [XX] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1977	52	02/01/77	$ 155,817	Not Available	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		52		$ 155,817 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [XX] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/01/77
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	01/31/2003	$ N/A (will be cost)
13.	01/31/2004	$ N/A (will be cost)
14.	01/31/2005	$ N/A (will be cost)

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [XX] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [XX] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	440	$	21,639	$	440	$ 21,639	1
2	Licensed Speech and Language Development Therapist	10a	hrs		12		1,366		12	1,366	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a	hrs		709		34,863		709	34,863	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39	# of prescrpts		6,041			14,269	6,041	14,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	7,202	$	57,868	$ 14,269	7,202	$ 72,137	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Home of Chicago # 0007914 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,915	$ 7,695,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	343,608	8,478,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		9,136,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,388,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 354,523	$ 26,697,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		94,468,000	12
13	Land		15,815,000	13
14	Buildings, at Historical Cost		317,757,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	110,568	44,147,000	16
17	Accumulated Depreciation (book methods)	(70,439)	(123,145,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	53,561	39,547,000	21
22	Other Long-Term Assets (specify):		20,064,000	22
23	Other(specify): Construction In Progress		27,451,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 93,690	$ 436,104,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 448,213	$ 462,801,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,920	$ 6,267,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		2,819,000	28
29	Short-Term Notes Payable		7,685,000	29
30	Accrued Salaries Payable	54,455	3,014,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	(30)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		1,540,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expense	3,920	3,426,000	36
37	Other Current Liabilites	10,915	5,370,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 102,180	$ 30,121,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		194,901,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Accts, Other Liabilities	(185,013)	12,340,000	43
44	Deferred Revenue		159,421,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (185,013)	$ 366,662,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 82,832	$ 396,783,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 531,045	$ 66,018,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 448,213	$ 462,801,000	48

***(See instructions.)**

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 250,637	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 250,637	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,503	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Planned Giving Assessment)**	(2,095)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 280,408	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 531,045	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,573,550	1
2	Discounts and Allowances for all Levels	(321,284)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,252,266	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	125,425	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 125,425	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,739	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,467	19
20	Radiology and X-Ray		20
21	Other Medical Services	137,662	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 182,810	23
	D. Non-Operating Revenue		
24	Contributions	20,742	24
25	Interest and Other Investment Income***	6,106	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,848	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Benevolent Care	29,827	28
28a	Other Operating Revenue/Rounding	99	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,926	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,617,275	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	446,983	31
32	Health Care	1,187,982	32
33	General Administration	473,348	33
	B. Capital Expense		
34	Ownership	171,720	34
	C. Ancillary Expense		
35	Special Cost Centers	54,739	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,334,772	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,503	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 282,503	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,852	2,080	$ 56,245	$ 27.04	1
2	Assistant Director of Nursing	1,832	2,120	42,588	20.09	2
3	Registered Nurses	13,039	15,012	260,429	17.35	3
4	Licensed Practical Nurses	5,769	6,489	97,515	15.03	4
5	Nurse Aides & Orderlies	36,875	41,892	406,892	9.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2	2	(603)	-301.50	7
8	Rehab/Therapy Aides					8
9	Activity Director	948	1,040	17,514	16.84	9
10	Activity Assistants	2,168	2,403	32,045	13.34	10
11	Social Service Workers	1,204	1,421	25,395	17.87	11
12	Dietician					12
13	Food Service Supervisor	1,627	1,794	35,035	19.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,907	12,107	107,911	8.91	15
16	Dishwashers					16
17	Maintenance Workers	737	762	10,116	13.28	17
18	Housekeepers	5,461	5,759	49,546	8.60	18
19	Laundry	657	742	6,423	8.66	19
20	Administrator	1,040	1,040	36,039	34.65	20
21	Assistant Administrator					21
22	Other Administrative	1,088	1,248	22,287	17.86	22
23	Office Manager					23
24	Clerical	1,341	1,570	25,788	16.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,899	2,197	25,085	11.42	31
32	Other Health Care(specify)	1,842	2,104	20,589	9.79	32
33	Other(specify) Mktng & Trans	593	684	10,944	16.00	33
34	TOTAL (lines 1 - 33)	90,881	102,466	$ 1,287,783 *	$ 12.57	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	135	$ 6,319	1,3	35
36	Medical Director	Monthly	5,335	9,3	36
37	Medical Records Consultant	Monthly	1,600	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	945	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,700	11,3	44
45	Social Service Consultant	20	1,000	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	183	$ 16,899		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	228	6,637	10,3	51
52	Nurse Aides	830	14,362	10,3	52
53	TOTAL (lines 50 - 52)	1,058	$ 20,999		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mueller, Barbara	Administrator	0.00	$ 31,532
Fringe Benefit Reclass			4,507
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,039

B. Administrative - Other

Description	Amount
Covenant Retirement Communities, Inc.	$ 63,588
TOTAL (agree to Schedule V, line 17, col. 3)	$ 63,588
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche, CPA's	Audit Services	$ 5,439
ADP	Payroll Services	3,772
Covenant Retirement Comm. Inc.	Data Processing Services	7,164
EricksonPapanek	Legal Services	7,226
FR & R Consulting	Consultant Services	
Scutillo & Blake, CPA,PA	Cost Report Preparation	3,000
Heilman Consulting	Medical Records Cons.	320
Alan Forsman	Dept. Mgr. Training	600
Other Consulting		513
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,034

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,686
Unemployment Compensation Insurance	3,772
FICA Taxes	75,615
Employee Health Insurance	162,167
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	7,510
Pension Plan	4,093
Administrator Fringe Benefit Reclass	4,507
TOTAL (agree to Schedule V, line 22, col.8)	$ 270,350

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,694
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	5,480
Public Relations	1,063
Non Allowable Dues & Subscriptions	(59)
Less: Public Relations Expense	(1,063)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,115

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 698
(Not Allowable)	(698)
In-State Travel	606
(Not Allowable)	(606)
Seminar Expense	1,503
(Not Allowable)	(446)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,057

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Covenant Home of Chicago # 0007914 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $2,056**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,950** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **XX** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **XX** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **28,470**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,915**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate Records Maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.